IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-5747
FAX: (208) 364-1811

December 10, 2007

Melissa Wolfe, Administrator
Wolfe Creesk-Hillcrest Manor
4660 Hatchery Road
Eagle, ID 83616

License #: RC-876

Dear Ms. Wolfe:

On August 8, 2007, a complaint investigation, initial licensure survey was conducted at Wolfe Creek Assisted Living Communities-Hillcrest Manor. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Core issues, which are described on the Statement of Deficiencies, and for which you have submitted a Plan of Correction.

- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

This office is accepting your submitted plan of correction and evidence of resolution.

Should you have questions, please contact Polly Watt-Geier, MSW, Health Facility Surveyor, Residential Community Care Program, at (208) 334-6626.

Sincerely,

Polly Watt-Geier

POLLY WATT-GEIER, MSW
Team Leader
Health Facility Surveyor
Residential Community Care Program

PWG/sc

c: Jamie Simpson, MBA, QMRP Supervisor, Residential Community Care Program

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-5747
FAX: (208) 364-1811

August 20, 2007

CERTIFIED MAIL #: 7003 0500 0003 1967 0896

Sandra Eggebraaten, Administrator
Hillcrest Manor
2087 S Tollgate Way
Boise, ID 83709

Dear Ms. Eggebraaten:

Based on the complaint investigation, initial licensure survey conducted by our staff at Wolfe Creek Assisted Living Communities, Inc-Hillcrest Manor on **August 8, 2007,** we have determined that the facility failed to protect residents from inadequate care. Based on observation, interview and record review, it was determined the facility failed to provide assistance and monitoring of medications for 4 of 4 sampled residents (#'s 1, 2, 3, & 4).

This core issue deficiency substantially limits the capacity of Wolfe Creek Assisted Living Communities, Inc-Hillcrest Manor to furnish services of an adequate level or quality to ensure that residents' health and safety are safe-guarded. The deficiency is described on the enclosed Statement of Deficiencies.

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of this deficiency must be achieved by **September 22, 2007.** **We urge you to begin correction immediately.**

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction by answering **each** of the following questions for **each** deficient practice:

- What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?
- How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action(s) will be taken?
- What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
- How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?
- What date will the corrective action(s) be completed by?

Return the **signed** and **dated** Plan of Correction to us by **September 1, 2007,** and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

In accordance with Informational Letter #2002-16 INFORMAL DISPUTE RESOLUTION (IDR) PROCESS, you have available the opportunity to question cited deficiencies through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Chief of the Bureau of Facility Standards for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the statement of deficiencies (**September 1, 2007**). The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for the Bureau of Facility Standards to determine the basis for the provider's appeal. If your request for informal dispute resolution is received after **September 1, 2007,** your request will not be granted.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The completed punch list form and accompanying proof of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **September 8, 2007**.

If, at the follow-up survey, it is found that the facility is not in compliance with the rules and standards for residential care or assisted living facilities, the Department will have no alternative but to initiate an enforcement action against the license held by Wolfe Creek Assisted Living Communities, Inc-Hillcrest Manor.

Should you have any questions, or if we may be of assistance, please call our office at (208) 334-6626.

Sincerely,

JAMIE SIMPSON, MBA, QMRP
Supervisor
Residential Community Care Program

JS/slc

Enclosure

c: Lynne Denne, Program Manager, Regional Medicaid Services, Region IV - DHW

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R876	A. BUILDING _____ B. WING _____	08/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOLFE CREEK ASSISTED LIVING COMMUN-I	3901 W HILLCREST DRIVE BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	Initial Comments The following deficiencies were cited during the initial health care survey and complaint investigation survey conducted at your residential care/assisted living facility. The surveyors conducting your survey were: Polly Watt-Geier, MSW Team Coordinator Health Facility Surveyor Rachel Corey, RN Health Facility Surveyor Debbie Sholley, LSW Health Facility Surveyor Survey Definitions: MAR = Medication Administration Record mg = milligrams PO = By Mouth PRN = As Needed GM = gram Five Rights of Medication Assistance = Right Resident Right Route Right Medication Right time Right dose	R 000		
R 008	16.03.22.520 Protect Residents from Inadequate Care. The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care. This Rule is not met as evidenced by:	R 008		

Bureau of Facility Standards

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R876	A. BUILDING _____ B. WING _____	08/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOLFE CREEK ASSISTED LIVING COMMUN-I-	3901 W HILLCREST DRIVE BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 1 Based on observation, interview and record review it was determined the facility failed to provide assistance and monitoring of medications for 4 of 4 sampled residents (#'s 1, 2, 3, & 4). The findings include: I. Facility did not follow physician's orders A. Review of Resident #3's record on 8/7/07, revealed the resident was admitted on 3/1/07 with diagnoses which included Post Traumatic Stress Disorder and schizophrenia. Resident #3's record contained a physician's order dated 3/28/07, which documented the resident was to take: * Cymbalta 60 mg two capsules every morning. Review of the resident's MAR for the month of July, 2007 revealed the resident did not receive her Cymbalta on 7/18/07, 7/19/07, and 7/20/07. Review of Resident #3's MAR for the month of August, 2007 documented the resident did not receive her Cymbalta on 8/1/07, 8/2/07, 8/3/07, 8/4/07, 8/5/07, and 8/6/07. On 8/7/07 at 9:20 a.m., the administrator stated she was having a difficult time getting the blister pack of Cymbalta and needed to call the pharmacy again to check on the medication. On 8/7/07 at 9:25 a.m., a blister pack of Cymbalta 60 mg capsules were observed in the resident's medication box. There was one capsule missing from the blister pack. At this same time the administrator stated she was not aware the pharmacy had delivered the Cymbalta.	R 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R876	A. BUILDING _____ B. WING _____	08/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOLFE CREEK ASSISTED LIVING COMMUN-I	3901 W HILLCREST DRIVE BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 2 There was no documentation on the resident's MAR to indicate the resident received the missing capsule from the blister pack. B. Review of Resident #2's record on 8/7/07, revealed the resident was admitted on 3/7/07 with diagnoses which included borderline personality, bipolar disorder, schizoaffective disorder and fibromyalgia. Resident #2's record contained a physician's order dated 7/20/07, which documented the resident was to take: * Metamucil 1 packet in 8 ounces of water once daily Resident #2's record contained a physician's order dated 7/21/07, which documented the following: * polyethlene glycol powder 3350 NF #527 (Miralax); mix one capful (17 GM) in 8 ounces of water or juice and drink by mouth twice daily. The order documented to "discontinue Metamucil packet not covered - over the counter, use Miralax." Resident #2's August, 2007 MAR documented Miralax mix capful (17 GM) in 8 ounces of water or juice and drink by mouth twice daily. The block on the MAR had a line through it and documented "Not Reordered on 7/20/07". Additionally, it had not been signed by the caregivers as given from the evening of August 3, 2007 through August 8, 2007, which resulted in the resident not being assisted with 11 doses of Miralax. On 8/7/07 at 1:52 p.m., the Miralax powder was	R 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R876	A. BUILDING _____ B. WING _____	08/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOLFE CREEK ASSISTED LIVING COMMUN-I-	3901 W HILLCREST DRIVE BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 3 observed sitting in a locked cabinet that was used to store unused or discontinued medications. On 8/7/07 at 2:15 p.m., the administrator stated she may have overlooked the order for the Metamucil and then had not been aware of the physician's order to discontinue the Metamucil and start the resident on the Miralax. C. Review of Resident #3's MAR for the month of July, 2007 documented the resident's blood glucose levels were to be checked at the following times: Monday - fasting in the a.m. and then 2 hours after breakfast Wednesday - fasting in a.m. and 2 hours after lunch Friday - fasting in a.m. and 2 hours after dinner Review of Resident #3's "Blood Glucose Tracking" form dated August , 2007 documented on Wednesday 8/1/07 the resident's blood glucose levels were not checked 2 hours after the lunch time meal. On Friday 8/3/07 the resident's blood glucose levels were not checked 2 hours after the dinner time meal. On Monday 8/6/07 the resident's blood glucose level was not checked 2 hours after the breakfast meal. On 8/7/07 a 9:10 a.m., the administrator stated, "With new trainees blood sugars have been missed." D. Review of Resident #1's record on 8/7/07, revealed the resident was admitted on 2/15/07 with diagnoses which included a Cerebral Vascular Accident and Type II non-insulin dependent diabetes.	R 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R876	A. BUILDING _____ B. WING _____	08/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOLFE CREEK ASSISTED LIVING COMMUN-I	3901 W HILLCREST DRIVE BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 4 Review of the resident's MAR for August, 2007 documented the resident's blood glucose levels were to be checked before each meal and at bedtime. On 8/7/07 at 1:15 p.m., the administrator stated she did not know where the form was to document the blood glucose levels on, or whether or not they were even being documented. E. On 8/7/07 at 7:35 a.m., the facility owner was observed assisting Resident #4 with her Mylanta. The Mylanta order was for two teaspoons every morning. Initially, the owner was observed to pour the Mylanta into a small paper cup that did not have measurement markings on it. The owner then asked the resident to get a teaspoon from the kitchen. The resident brought back a regular kitchen spoon and the owner poured the Mylanta onto the spoon for the resident to ingest. The facility owner did not use a measuring device to ensure Resident #4 received her Mylanta as ordered by the physician. The facility did not assist Resident #1, #2, #3, & #4 with their medications as ordered by their physicians II. The facility did not ensure MAR's and medication labels were congruent with physician's orders A. Review of Resident #3's record on 8/7/07, revealed the resident was admitted on 3/1/07 with diagnoses which included Post Traumatic Stress Disorder and schizophrenia. Resident #3's record contained two physician orders dated 7/5/07 and 5/29/07, which	R 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R876	A. BUILDING _____ B. WING _____	08/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOLFE CREEK ASSISTED LIVING COMMUN-I	3901 W HILLCREST DRIVE BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 5 documented the resident was to take: * Cymbalta 60 mg one capsule every morning. * Motrin 800 mg, po three times daily prn. Resident #3's MAR dated 8/1/07 was hand written to read: * Cymbalta 60 mg two capsules every morning. * Motrin one tab every day prn. On 8/7/07 at 9:20 a.m., the administrator confirmed she was the one that had transcribed the Cymbalta and the Motrin orders incorrectly on the August, 2007 MAR. B. Review of Resident #2's record on 8/7/07, revealed the resident was admitted on 3/7/07 with diagnoses which included borderline personality, bipolar disorder, schizoaffective disorder and fibromyalgia. Resident #2's record contained a physician's order dated 7/20/07, which documented the resident was to take: * Colace 100 mg by mouth twice daily. Review of Resident #2's August, 2007 MAR, documented the resident was to receive docusate sodium (Colace) "two capsules (200 mg) by mouth twice daily. The MAR documented from the morning of 8/1/07 through the morning of 8/3/07, the resident had received 2 capsules of docusate sodium.	R 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R876	A. BUILDING _____ B. WING _____	08/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOLFE CREEK ASSISTED LIVING COMMUN-I	3901 W HILLCREST DRIVE BOISE, ID 83705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 6 On 8/7/07 at 1:45 p.m., Resident #2's bubble pack which was filled on 7/18/07, contained docusate sodium which was labeled, "two capsules (200 mg) by mouth twice daily. The bubble pack was also observed to contain 2 capsules of docusate sodium, rather than one capsule as ordered by the physician. On 8/7/07 at 2:15 p.m., the administrator confirmed the bubble packs contained 2 capsules of docusate sodium and the label had not been updated when a new order had been given to the facility on 7/20/07. The facility did not ensure the August, 2007 MAR was updated to reflect an order change for Resident #2's docusate sodium. Additionally, the facility did not ensure the label on the bubble pack was updated to reflect the physician's order, which resulted in the resident receiving an additional 200 mg every day of docusate sodium from August 1, 2007 through August 3, 2007. The facility did not follow physician orders for Resident #2 and #3's scheduled medication orders. The facility did not follow physician's orders to check Resident #1 and #3's blood sugar levels. The facility did not follow the five rights of medication assistance to ensure the correct dosage was given to Resident #4 to coincide with the physician's orders. Additionally, the facility did not accurately transcribe physician orders onto the MAR for Resident #2 and #3. Similarly, the facility did not ensure the label on the bubble pack for Resident #2 was updated to reflect the physician's order. This failure resulted in inadequate care.	R 008		

September 1, 2007

Dept. of Health & Welfare
Bureau of Facility Standards
P.O. Box 83720
Boise, ID 83720-0036

Hillcrest House
Plan of Correction from Core Issue Survey dated August 8, 2007

ITEM #	RULE #	DESCRIPTION	EVIDENCE OF RESOLUTION	DATE RESOLVED
R008	520	Protect Residents from Inadequate Care	1. WHAT CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE SPECIFIC RESIDENTS/PERSONNEL/AREAS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICES?	8-9-07
	I	Facility did not follow physicians orders		
A		Resident #3 did not receive her Cymbalta on 8/1 thru 8/6/2007	The MAR was corrected to reflect exact orders by the physician, copies attached, and the bubble packs were compared to the medication orders and the MAR to reflect exact orders by the physician.	
B		Resident #2 did not receive 11 doses of Polyethleneglycol powder		
C		Resident #3 did not receive her routine blood glucose levels as prescribed by physician		
D		Resident #1's form for documented BG levels could not be located, therefore there is no documentation that Resident #1 BG levels were checked.	2. HOW WILL YOU IDENTIFY OTHER RESIDENTS / PERSONNEL / AREAS THAT MAY BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION(S) WILL BE TAKEN?	
E		The facility owner did not use a liquid measuring device to ensure Resident #4 received her Mylanta dose as ordered by the physician.	It is assumed that all residents could be affected by the same deficient practice.	
			3. WHAT MEASURE WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?	
			a. The checklist/procedure for medication (new/change/D/C) has been expanded for more administrator review. b. The checklist/procedure for new month medication check-in has been	

			expanded. The Administrator will review these medications prior to the 1st of each month. c. The DAILY medication and communication checklist has been expanded to include staff self-auditing for BG levels as exactly prescribed by the physician, and staff self-auditing for any med changes. 4. HOW WILL THE CORRECTIVE ACTION(S) BE MONITORED AND HOW OFTEN WILL MONITORING OCCUR TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR. a. The Administrator will review at the end of every month the procedure for the new months medication check-in. b. The Administrator will review the signed order and the procedural checklist for any new or change in medication.. c. The Administrator will check in with the facility daily to discuss any new medication orders for any resident. That documentation is included on the Daily Medication checklist #2. d. Quality assurance program is 1) expanded Daily medication checklist #2, 2) expanded Checklist/Procedure for medication: new/change/D/C, and 3) expanded checklist/procedure check-in of medications for the new month. These checklists are attached. 5. WHAT DATE WILL THE CORRECTIVE ACTION(S) BE COMPLETED BY. These actions were completed by 8-9-07	
A	II	The facility did not ensure MAR's and medication labels were congruent with physician's orders. Resident #3 MAR description for		8-9-07

B			Cymbalta and Motrin did not match physician signed orders. The facility did not ensure the August 2007 MAR was updated to reflect an order change for Resident #2's docusate sodium. Additionally the facility did not ensure the label on the bubble pack was updated to reflect the physician's order.		
			THEREFORE: 1. The facility did not follow physician orders for Resident #2 and #3's scheduled medication orders. 2. The facility did not follow physician's orders to check Resident #1 and #3's blood sugar levels. 3. The facility did not follow the five rights of medication assistance to ensure the correct dosage was given to Resident #4 to coincide with the physician's orders. 4. The facility did not accurately transcribe physician orders onto the MAR for Resident #2 and #3. 5. The facility did not ensure the label on the bubble pack for Resident #2 was updated to reflect the physician's order.		8-9-07

Sandra J. Eggebraaten

Sandra J. Eggebraaten
Administrator
Hillcrest House
Wolfe Creek Assisted Living Communities
2087 S. Tollgate Way
Boise, ID 83709

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-5747
FAX: (208) 364-1811

August 20, 2007

Sandra Eggebraaten, Administrator
Hillcrest Manor
2087 S Tollgate Way
Boise, ID 83709

Dear Ms. Eggebraaten:

On August 8, 2007, a complaint investigation survey was conducted at Wolfe Creek Assisted Living Communities, Inc-Hillcrest Manor. The survey was conducted by Rachel Corey, RN, Polly Watt-Geier, MSW and Debra Sholley, LSW. This report outlines the findings of our investigation.

Complaint # ID00003052

Allegation #1: The facility did not protect residents' personal property.

Findings #1: Based on interview and record review it could not be determined the facility did not protect residents' personal property.

On August 8, 2007 between 7:00 a.m. and 3:00 p.m., four random residents interviewed denied the facility did not protect their personal property.

Review of the facility's complaint log revealed no documented evidence of any complaints regarding personal property not being protected.

Conclusion #1: Unsubstantiated. Although the allegation may have occurred, it could not be validated during the complaint investigation.

Allegation #2: The facility left medications out on counters and tables and caused an increased potential for harm.

Findings #2: Based on interview it was determined the facility left medications out on counters and tables and caused increased potential for harm.

On August 8, 2007 at 8:30 a.m., the administrator stated a few months ago when she was training a new staff, medications were left unsupervised on the kitchen table and a prior resident took another resident's blister pack of medication.

Conclusion #2: Substantiated. However, the facility was not cited as they acted appropriately by changing their medication administration system. Medications were moved into a locked office and stored in a locked cabinet that could be viewed continuously during the medication administration process. During observation of medication pass on August 7, 2007 at 7:00 am, no medications were left unsupervised.

Allegation #3: The complainant alleged female resident's boyfriend visited the facility and violated other residents' dignity and respect.

Findings #3: Based on interview it could not be determined residents' right to dignity and respect was violated.

On August 7, 2007 from 7:55 am through 8:30 am five residents interviewed stated they were treated with dignity and respect by the identified resident's boyfriend.

Conclusion #3: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Allegation #4: Staff stay in their living quarters and residents are left unsupervised.

Findings#4: Based on observation and interview it could not be determined that residents were left unsupervised.

From August 6, 2007 through August 8, 2007 staff were observed to provide supervision to residents.

From August 6, 2007 through August 8, 2007 five random residents interviewed, denied staff did not provide adequate supervision.

Conclusion #4: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Allegation #5: The facility does not address residents' complaints.

Findings#5: Based on interview, it could not be determined the facility did not address residents' complaints.

From August 6, 2007 through August 8, 2007, five random residents interviewed stated their complaints were addressed through the complaint log and community meetings.

On August 7, 2007 at 3:00 p.m., the administrator stated complaints were reported either through use of a complaint log or in person. The administrator notifies the owners who investigate the complaint and then informs the complainant of the findings.

Conclusion #5: Unsubstantiated. Although the allegation may have occurred, it could not be validated during the complaint investigation.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

POLLY WATT-GEIER, MSW
Team Leader
Health Facility Surveyor
Residential Community Care Program

PWG/sc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program
Polly Watt-Geier, MSW, Health Facility Surveyor

IDAHO DEPARTMENT OF HEALTH & WELFARE

BUREAU OF FACILITY STANDARDS
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING
Non-Core Issues Punch List

Facility Name	Physical Address	Phone Number
Wolfe Creek Hilcrest	3901 W. Hillcrest Drive	424-0618
Administrator	**City**	**ZIP Code**
Sandy Eggebraaten	Boise	83705
Survey Team Leader	**Survey Type**	**Survey Date**
Dolly Watt-Geier	Initial/Complaint	8/8/07

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
1	210	The facility did not provide an ongoing program of activities for Residents.		11/14/07 Pass
2	250.09	The mens bathroom fan was nonworking. The second female's bathroom fan was not functioning properly.		11/14/07 Pass
3.	260.04.A	The bleach in laundry room was not stored under lock & key.		11/19/07 Pass
4	305.06	The facility Nurse did not assess resident #1 & 3 to Self administer Medications (Inhalers, medications for Day treatment)		11/19/07 Pass
5	710.04	The facility did not have a history and Physical for residents #1 and #3, ~~prior~~ within 6 months prior to admission.		11/14/07 Pass
6	711.01	The facility did not have behavioral Management records for Residents #1 & 2 that included consistent monitoring of behaviors to include date & time, interventions and effectiveness of interventions.		11/08/07 Pass

Response Required Date	Signature of Facility Representative	Date Signed
9/8/07	Sandra J Eggebraaten	8-8-07

IDAHO DEPARTMENT OF HEALTH & WELFARE

BUREAU OF FACILITY STANDARDS
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING
Non-Core Issues Punch List

Facility Name	Physical Address	Phone Number
Wolfe Creek Hillcrest	3901 W. Hillcrest Drive	424-0618
Administrator	**City**	**ZIP Code**
Sandra Eggebraaten	Boise	83705
Survey Team Leader	**Survey Type**	**Survey Date**
Polly Watt-beier	Initial / Complaint	8/8/07

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
7	711.07	The facility did not maintain copies of care plans prepared by outside services ie day treatments for resident #3		
8	711.08E	The facility did not notify R.N of a change in resident #3 & 2's mental condition.		
9	711.08F	The facility did not maintain care notes from case managers and psychosocial rehab specialists (PSR worker) for resident #2 & 3.		

Response Required Date	Signature of Facility Representative	Date Signed
9/8/07	Sandra J Eggebraaten	8-8-07